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No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER

Petitioner,

v.

BLUE CROSS OF KANSAS CITY and
BLUE CROSS ASSOCIATION

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974, as amended, directs a Health Systems Agency (in this case a private Missouri corporation engaged in health planning activities) to "seek, to the extent practicable, to implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan] with the assistance of individuals and public and private entities in its health service area."

The question presented is whether this general statutory language is so inconsistent with the antitrust laws that it should be construed to grant a blanket exemption from those laws for a concerted refusal to deal by Blue Cross of Kansas City, Blue Cross Association, and other persons, where there was no involvement by a state or federal agency, where there was no state or federal mandate or supervision of the parties or conduct involved, and where the federal statute did not expressly immunize the boycott.

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National Gerimedical Hospital and Gerontology Center ("National Gerimedical") respectfully prays that a writ of certiorari be issued to review the decision of the United States Court of Appeals for the Eighth Circuit in this case, entered on July 22, 1980.

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Eighth Circuit is reported at 628 F.2d 1050, and is set out below as Appendix A, *infra*, pp. 1a-15a. The Order of the District Court for the Western District of Missouri is reported at 479 F. Supp. 1012, and is set forth in Appendix B, *infra*, pp. 17a-44a.

JURISDICTION

The judgment of the United States Court of Appeals for the Eighth Circuit was entered on July 22, 1980, and is set out in Appendix C, *infra,* p. 45a. A petition for rehearing and rehearing en banc was denied on August 22, 1980. The order of denial is set out in Appendix D, *infra,* p. 47a.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations is declared to be illegal.

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony.

Section 300*l*-2(c)(1) of the National Health Planning and Resources Development Act, as amended, as it appears in 42 U.S.C., provides:

> A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:
>
> > (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

STATEMENT

This case involves a boycott of a nonprofit hospital by private health care reimbursement organizations. The facts before the court below may be summarized as follows:[1]

The petitioner, National Gerimedical, is a fully accredited, general acute care community hospital which opened on October 16, 1978. (D.R. at 2 and D.R. Supp. at 15.) It has been continuously licensed by the Missouri Division of Health since September, 1977, and has been fully certified as a Medicare provider by the Department of Health, Education and Welfare (now Health and Human Services) since its opening. (D.R. Supp. at 14.) One of the respondents, Blue Cross of Kansas City ("Blue Cross"), is a Missouri Health Services Corporation which markets and sells prepaid health reimbursement plans to the public, and contracts with health care providers to administer the plans. (D.R. at 2; 479 F. Supp. at 1015; App. B at 20a.) The other respondent, Blue Cross Association ("BCA") is a national organization to which local Blue Cross plans, including Blue Cross, belong. (D.R. at 2, 198.)

Prior to opening in 1978, petitioner sought to enter into a participating hospital agreement with Blue Cross. This was important to National Gerimedical's economic viability; participating hospitals receive directly one hundred percent reimbursement for covered hospital services rendered to Blue Cross subscribers, while reimbursement for covered services at nonparticipating hospitals is made, not to the hospital, but directly to the subscriber and only for up to eighty percent of the cost of the services. (D.R. at 4; 479 F. Supp. at 1015-16; App. B at 20a.) It was feared (and rightly so) that denial of participation would discourage Blue Cross subscribers from seeking services at National Gerimedical, thereby placing it at a substantial competitive disadvantage. (D.R. at 7; D.R. Supp.

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[1] Citations to the record below are to the Designated Record on Appeal, cited "D.R.", and to the Supplementary Designated Record on Appeal, cited "D.R. Supp."

at 19.) Blue Cross' individual members account for approximately one-fourth of all area hospital admissions, and all licensed general acute care community hospitals in Blue Cross' service area except National Gerimedical have Blue Cross participating contracts. (D.R. at 4, 261; 479 F. Supp. at 1015; App. B at 20a.)

On March 21, 1978, Blue Cross refused to enter into a participating hospital contract with National Gerimedical solely because it had not sought nor obtained a "finding of need" from the Mid-America Health Systems Agency ("MAHSA"), a private, not-for-profit Missouri corporation engaged in voluntary health planning activities which is funded as a health systems agency within the terms of the National Health Care Planning and Resources Development Act of 1974 ("Planning Act"), 42 U.S.C. §§ 300k *et seq.*[2] (D.R. at 5; 479 F. Supp. at 1016; App. B at 21a.) The "finding of need" requirement was imposed by Blue Cross pursuant to BCA policy guidelines adopted in 1976. (D.R. at 5.)

During the time at issue, no federal or Missouri law required National Gerimedical to seek or secure "need" review.[3] In addition, MAHSA had publicly declared that it would

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[2] The Planning Act established three types of health planning agencies. (*See* 42 U.S.C. §§ 300*l*-1, 300m, 300m-3.) The only type relevant here, Health Systems Agencies (HSAs), may be nonprofit, private corporations, public regional planning bodies, or single units of local governments. 42 U.S.C. § 300*l*-1(b)(1)(A)-(C). MAHSA, which is a private corporation, was conditionally designated by the Secretary of the Department of Health, Education, and Welfare (now Health and Human Services ("HHS")) as one of 205 regional health systems agencies under the Planning Act on April 12, 1976. (D.R. at 18.)

[3] At the time petitioner's complaint was filed and at all pertinent times, Missouri had neither enacted a compulsory certificate of need program, nor designated a State Health Planning and Development Agency in accordance with 42 U.S.C. § 300m. Both are prerequisites to any requirement under the Planning Act to seek "need" review by

(footnote continues)

disapprove the addition of any additional acute care hospital beds. (D.R. at 6; 479 F. Supp. at 1016; App. B at 21a.) For these reasons, National Gerimedical did not seek review by MAHSA, and Blue Cross thereafter denied the petitioner's request for participating hospital status solely because of its lack of a favorable "need" determination by MAHSA. (D.R. at 5; 479 F. Supp. at 1016; App. B at 21a.)

Proceedings Below

On May 23, 1978, National Gerimedical filed an antitrust complaint in the United States District Court for the Western District of Missouri against Blue Cross and BCA, in which it named MAHSA and others as non-defendant co-conspirators.[4] The complaint alleged that a collective refusal to deal by Blue Cross and BCA, acting in concert with the named non-defendant co-conspirators, constituted a violation of Section 1 of the Sherman Act, and that Blue Cross' actions, standing alone, violated Section 2 of that Act. (D.R. at 5-9; 479 F. Supp. at 1014; App. B at 17a-18a.)

On July 14, 1978, BCA and Blue Cross moved to dismiss the complaint on a variety of grounds. (479 F. Supp. at 1014;

(footnote continued)

the relevant HSA. *See* 42 U.S.C. § 300m-2(a)(4)(A). In August, 1979, Missouri enacted a Certificate of Need Law (Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980)) which, by its terms, became fully effective in October, 1980. Under the provisions of that law, petitioner is deemed to have received a certificate of need for purposes of the state regulatory program. Despite this legislative determination, petitioner was denied participating hospital status by Blue Cross solely because it did not comply with Blue Cross' unilateral "need" review requirement.

[4] The other non-defendant co-conspirators named were all individuals who served simultaneously as members of the Board of Trustees of Blue Cross and the Board of Directors of MAHSA, or were employees of Blue Cross serving as members of the MAHSA Board of Directors, or were individuals employed by competitors of National Gerimedical who served on the Blue Cross Board of Directors.

App. B at 18a.) On November 2, 1979, the district court, treating the motion as one for summary judgment, held that the complaint stated a cause of action under Section 1; that the requisite effect on interstate commerce had been properly alleged; and that the conduct involved was not exempt from antitrust scrutiny under Section 2 of the McCarran-Ferguson Act (15 U.S.C. § 1012), as that exemption was construed by this Court during the pendency of this action in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205. (479 F. Supp. at 1016-19, 1024-26; App. B at 22a-27a, 38a-42a.) Nevertheless, the district court granted summary judgment for defendants, finding that the Planning Act[5] created an implied "blanket exemption" from the antitrust laws for any and all voluntary private action "taken pursuant to the Act and clearly within the scope of the Act." (479 F. Supp. at 1021, 1024; App. B at 32a, 37a.) In so doing, it relied primarily on Section 300*l*-2(c)(1) of the Act which merely directs HSAs to seek the assistance of individuals, and public and private entities in implementing their health service plans,[6] and on the MAHSA plan itself, which states as objectives various cost containment goals. On this basis, the court concluded that "the certificate of need requirement voluntarily adopted by Blue Cross seems to be authorized by the Act as well as by the MAHSA Implementation Plan." (479 F. Supp. at 1021; App. B at 32a.) The court concluded that there was an irreconcilable conflict between the antitrust laws and the National Health Planning and Resources Development Act of 1974, which required not merely an

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[5] 42 U.S. §§ 300k *et seq.*

[6] Section 300*l*-2(c)(1) reads as follows:

> A health systems agency shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
>
> > (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

exemption for the specific conduct at issue, but rather a "blanket" exemption from the antitrust laws for any and all private actions ostensibly taken to further the public policy goals of the Act. (479 F. Supp. at 1021; App. B at 32a.)

The Court of Appeals, noting that the district court's finding of implied immunity for Blue Cross rested primarily on Section 300*l*-2(c)(1) of the Act (628 F.2d at 1052; App. A at 3a-4a), affirmed the decision.

REASONS FOR GRANTING THE WRIT

I

The Court Below Has Decided An Important Question Of Federal Law Which Should Be Settled By This Court.

The question involved in this case—the effect of the Planning Act on the antitrust laws—is one which will frequently recur. The issue is whether the broad, general language of that Act should be construed to provide a "blanket" exemption from the long-established antitrust laws.

Clearly, there is no express repeal. In considering whether there is an implied repeal, it should be emphasized that no state or federal agency of any kind was involved in the conduct at issue here. The decision of the court below, which creates a "blanket" exemption from the antitrust laws for purely voluntary conduct undertaken by private parties with no supervision by any public body, is one of great potential significance. Before its influence is allowed to spread, the decision below should be reviewed by this Court.

A. The decision below, by largely displacing competition in the health care sector with unsupervised private action, presents an issue of critical national importance.

A basic premise of the economic system established by Congress in its exercise of the commerce power is that "the

unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway* v. *United States,* 356 U.S. 1, 4. The decision below, by creating a "blanket" exemption for voluntary activities undertaken in ostensible pursuit of health planning goals, will have the effect of removing from antitrust scrutiny many activities of the health care sector—a sector which already accounts for almost one-tenth of this nation's total GNP[7] and represents the largest single component of the services sector of our economy.[8] It is also a sector of our economy which has experienced sharply rising costs,[9] a phenomenon which, at least in part, may be due to the substantial immunity from the antitrust laws that the health care sector and third-party reimbursement organizations such as respondent Blue Cross have enjoyed in the past. *See* C. Havighurst and G. Hackbarth,

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[7] *See* M. Freeland, G. Calat & C. Schendler, "Projections of National Health Expenditures, 1980, 1985, and 1990," *Health Care Financing Review,* Winter, 1980, 1, 6. Between 1965 and 1978, health care expenditures as a percentage of GNP rose from 6.2% in 1965 to 9.1% in 1978, and are expected to rise to 11.5% by 1990. *Id.* at 6. Growth has been especially great for the services funded by third parties such as respondent Blue Cross. Health Care Financing Administration, *Health Care Financing Trends,* Spring, 1980, at 1. Many commentators have identified the prevalence of third party reimbursement programs as a major factor in rapidly rising health care costs. *See, e.g.,* "Projections of National Health Expenditures," *supra,* at 6 & n. 6; A. Kahn, "Health Care and Inflation: Social Compassion and Efficient Choice," *National Journal,* Aug. 2, 1980, at 1-2; C. Havighurst, "Controlling Health Care Costs: Strengthening the Private Sector's Hand," *J. of Health Politics, Policy, and Law,* Spring 1976/Winter 1977, 471, 475, 478-79, 481.

[8] *Health Services Policy Session* (briefing book prepared by Federal Trade Commission Staff, 1979) at 1.

[9] *See, e.g.,* "Skyrocketing Health Care Costs: The Role of Blue Shield," Hearings before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong., 2d Sess. (1978). *See also* "Projections," note 7, *supra.*

"Competition and Health Care: Planning for Deregulation," *Regulation,* May/June 1980, 39, 43; A. Kahn, "Health Care Economics: Paths to Structural Reform," American Enterprise Institute Conference on Health Care, Washington, D.C., Sept. 25, 1980, at 11.

Congress has recently emphasized the important role competition must play in the health care industry if skyrocketing costs are to be brought down. In 1979 Congress specifically amended the Planning Act to emphasize its concern about "diminished" competition in the health care industry.[10] The 1979 Amendments added "the strengthening of competitive forces in the health services industry" to the Planning Act's list of national health priorities (Pub. L. No. 96-79, § 103(a), 93 Stat. 594-95 (1979), 42 U.S.C. § 300k-2), and directed HSAs to foster the effects of competition where competition appropriately allocates supply. (*Id.,* § 103(b)(3), 93 Stat. 595, 42 U.S.C. § 300k-2(b)(3)). Thus, Congress has recently affirmed its understanding that competition is to play a significant role in the delivery of health care services.[11]

As one commentator, discussing the impact of this case, has noted, "[i]t would be anomalous, moreover, if a statute designed to make use of competition were interpreted to invalidate the means to enforce it." F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980). Yet, that is exactly what the court below did.

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[10] Health Planning and Resources Development Amendments of 1979, Act of October 4, 1979, Pub. L. No. 96-79, § 103(b)(1), 93 Stat. 592, 594-95 (1979).

[11] In *Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 374, this Court found that similar legislation indicating "an overriding policy of maintaining competition to the maximum extent possible consistent with the public interest" was persuasive evidence that "Congress rejected a pervasive regulatory scheme . . . . in favor of voluntary commercial relationships" which were fully subject to the antitrust laws.

B. Review of the decision below is required to clarify the ground rules governing antitrust liability in the health care industry.

The decision below, if allowed to stand, will open the question of implied repeal in a wide range of factual circumstances in the health care industry. In fact, this Court has recently dealt with one of these factual situations in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738.

In addition, there are currently pending cases presenting similar or related questions in the Sixth Circuit, *Huron Valley Hospital, Inc.* v. *City of Pontiac* (No. 79-1265, on appeal from the Eastern District of Michigan, 466 F. Supp. 1301 (1979)), and in the Western District of North Carolina, *North Carolina* v. *P.I.A. Asheville, Inc.* (Civ. No. A-C-80-29). These cases are summarized in the Addendum to this Petition, *infra,* pp. 27-28.

Further indication that this case is likely to stimulate many other cases in this area is provided by two recent Business Review Clearances by the Antitrust Division of the Department of Justice. These Executive determinations are likewise summarized in the Addendum, *infra,* pp. 28-30. In one of them, issued on May 6, 1980, the Department of Justice stated its views in these words:

> In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans.

Not surprisingly, many in the health planning sector did not agree with the Department's position, thereby setting the stage for conflict between the health planning sector and the Department of Justice on the issue of implied repeal. *See* "The Hospital Industry's New Vulnerability to Antitrust," *Regulation,* Sept./Oct. 1980, at 12; L. Demkovich, "Scaring The Planners, " *National Journal,* May 31, 1980, at 905.

Moreover, the impact of the decision below is also likely to be felt in the forthcoming program of "appropriateness review," in which the HSA periodically reviews all institutional health services in its area, and makes recommendations to the State Health Planning and Development Agency concerning the "appropriateness" of such services. *See* 42 U.S.C. §§ 300*l*-2(g), 300m-2(a)(6). Under the decision below, any action taken by private parties—no matter how anticompetitive—which ostensibly serves the goals of this program would also be immune from antitrust scrutiny.

Nor is the impact of the broad approach of the court below necessarily confined to private actions undertaken in response to the policy goals outlined in the Planning Act. For example, the federal legislation establishing Professional Standards Review Organizations ("PSROs")(*see* 42 U.S.C. §§ 1320c *et seq.*), like the Planning Act, establishes and funds local, private organizations to implement federal cost-containment policy objectives in the health area. If the decision below is allowed to stand, the rationale utilized in this case could readily be used to support the contention that the PSRO legislation, like the Planning Act, creates a blanket exemption from antitrust scrutiny for all activities undertaken by the PSRO and those who arguably assist the PSRO in implementing the objectives of the PSRO legislation, despite the fact that the PSRO system, like the Planning Act scheme, is subject to significant antitrust abuse, and despite the fact that it is generally acknowledged that PSROs should not be considered immune from the antitrust laws. *See* C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 *Duke L.J.* 303, 378 & n. 292 (1978); F. Grad, "The Antitrust Laws and Professional Discipline in Medicine," 1978 *Duke L.J.* 443, 482-84 (1978).

In short, the implied repeal issue presented in this case is a matter of major national concern. The decision below threatens to create inconsistent applications of the implied repeal doctrine to health planning activities in different sections of the country.

For example, in the Eighth Circuit, hospitals, under the decision below, would be able to allocate beds or services (activities which would clearly be illegal *per se* in the absence of the Planning Act),[12] or enter into virtually any other type of private "sharing" or other "cooperative" agreement with other hospitals under the guise of "planning." In other areas, many hospitals will probably be hesitant to participate in such "voluntary" sharing arrangements in light of the Justice Department's refusal to grant such schemes antitrust clearance under its Business Review procedure. *See* Addendum, *infra,* at pp. 28-30. Such inconsistency and uncertainty will not only have an adverse impact on the administration of the Planning Act,[13] but will also result in complex, time-consuming, and expensive litigation in the lower courts. Both of these results could be avoided by this Court's timely clarification of the implied repeal issue wrongly decided by the court below.

C. If allowed to stand, the decision below will impair the effect of recent decisions of this Court subjecting the health care industry to antitrust scrutiny.

Until very recently, health care providers and insurers were largely immune from the federal antitrust laws because of various legal hurdles which effectively shielded their conduct from antitrust scrutiny. *See, e.g.,* C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 *Duke L.J.* 303, 343 (1978). Recent decisions of this Court have, however, greatly diminished these barriers.

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[12] *See, e.g., Timken Roller Bearing Co.* v. *United States,* 341 U.S. 593; *United States* v. *Sealy, Inc.,* 388 U.S. 350; *United States* v. *Topco Associates, Inc.,* 405 U.S. 596.

[13] *See* L. Demkovich, "Plus Ça Change," *National Journal,* Oct. 4, 1980, at 1664 ("specter of antitrust prosecution hangs over the hospitals that meet to work out such sharing arrangements"). Sharing arrangements are apparently widespread. *See* E. Taylor, "Participation in Shared Programs Up Sharply, Survey Discloses," 51 *Hospitals* 192 (July 16, 1977).

First, in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, and *National Society of Professional Engineers* v. *United States,* 435 U.S. 679, this Court rejected the contention that the "learned professions" are exempt from the requirements of the antitrust laws.

Second, in *California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.,* 445 U.S. 97, and predecessor cases,[14] this Court significantly narrowed the *Parker* v. *Brown* [15] "state action" exemption, which now provides only a limited shield for private actions ostensibly taken by health professionals and third party insurers in response to state law and regulatory regimes. *See, e.g., Feminist Women's Health Center, Inc.* v. *Mohammad,* 586 F.2d 530, 549-50 (5th Cir. 1978), *cert. denied,* 444 U.S. 924; *Ballard* v. *Blue Shield of Southern West Virginia, Inc.,* 543 F.2d 1075, 1079 (4th Cir. 1976), *cert. denied,* 430 U.S. 922. Certainly after *Midcal* it is clear that private acts undertaken without state supervision are not exempt from antitrust scrutiny.

Third, and with special relevance to the health care industry, are this Court's recent decisions dealing with the scope of interstate commerce to which Section 1 of the Sherman Act (15 U.S.C. § 1) applies. For some time, hospitals and other health care providers have been able to contend successfully that the delivery of health services was a local activity, and, hence, not subject to the antitrust laws.[16] In *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, however, this

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[14] *See Cantor* v. *Detroit Edison Co.,* 428 U.S. 579; *City of Lafayette* v. *Louisiana Power & Light Co.,* 435 U.S. 389; *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773. *See also Bates* v. *State Bar of Arizona,* 433 U.S. 350; *New Motor Vehicle Bd. of California* v. *Orrin W. Fox Co.,* 439 U.S. 96.

[15] 317 U.S. 341.

[16] *See, e.g., Nankin Hospital* v. *Michigan Hospital Service,* 361 F. Supp. 1199, 1210 (E.D. Mich. 1973)(no interstate commerce in suit by private hospitals against Blue Cross for revocation of participating hospital contract because "sale of hospital care is personal and localized in nature").

Court significantly broadened the scope of interstate commerce in antitrust scrutiny of the health professions and other health care providers. The scope of interstate commerce under the Sherman Act was further extended by this Court's more recent decision in *McLain* v. *Real Estate Board of New Orleans*, 444 U.S. 232.

The decision below would effectively undo this Court's decision in *Rex Hospital*. Like the present case, *Rex Hospital* involved private anticompetitive conduct ostensibly undertaken pursuant to health planning legislation. Under the present decision, the very conduct in *Rex Hospital* ultimately held on remand to have been in violation of the antitrust laws,[17] would be shielded from antitrust scrutiny—this time not by the statutory interstate commerce hurdle but rather by a much more amorphous "blanket" exemption tenuously based on the Planning Act.

The decision below would also significantly limit the impact of this Court's decision in *Group Life and Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205. In the past, antitrust suits against Blue Cross/Blue Shield were often held to be barred by Section 2 of the McCarran-Ferguson Act (15 U.S.C. § 1012), which exempts the "business of insurance" from the Sherman Act if such business is regulated by state law.[18] In *Royal Drug*, this Court, noting that "exempting

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[17] On August 18, 1980, a judgment for plaintiff in the amount of $7,320,090 was entered on a jury verdict in the *Rex Hospital* case. Post-judgment motions have been filed by defendants.

[18] *See, e.g., Travelers Ins. Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093; *Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd per curiam*, 554 F.2d 1253 (3d Cir. 1977), *cert. denied*, 434 U.S. 860; *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976). *See also St. Bernard Hospital* v. *Hospital Service Ass'n of New Orleans*, 618 F.2d 1140 (5th Cir. 1980) (reversing lower court opinion holding participating hospital agreements immune from antitrust scrutiny in light of *Royal Drug*).

provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences" (440 U.S. at 232, n. 40), concluded that pharmacy provider agreements were not within the McCarran-Ferguson Act exemption. Yet, the court below has rendered such agreements and all their surrounding circumstances totally exempt from antitrust scrutiny. The impact of this decision on other related McCarran-Ferguson Act issues, such as those involved in *Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia,* 624 F.2d 476 (4th Cir. 1980), is less clear, but is not likely to be favorable to antitrust plaintiffs.

In short, the recent decisions of this Court have uniformly had the effect of narrowing the traditional antitrust exemptions applicable to health care providers and insurers.[19] What the opinion below does is to create a new blanket "Planning Act exemption" at least as broad as the antitrust exemptions traditionally used by health care providers and insurers (such as Blue Cross) to shield their conduct from antitrust scrutiny. Unless this Court's recent decisions are to be severely undercut, review of the decision below is required.

II

The Court Below Has Decided An Important Federal Question In A Way Which Is In Conflict With The Applicable Decisions Of This Court.

The decision below departs radically from the legal principles governing implied immunities from the antitrust laws as those principles have been established by this Court in a long

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[19] This has been consistent with the general inclination of this Court to read antitrust exemptions narrowly and to require a clear showing of Congressional intent before finding conduct exempt from antitrust scrutiny. *See, e.g., St. Paul Fire and Marine Ins. Co.,* v. *Barry,* 438 U.S. 531; *National Broiler Marketing Ass'n* v. *United States,* 436 U.S. 816.

line of decisions. Recognizing the "indispensable role of antitrust policy in the maintenance of a free economy," this Court has concluded that "[r]epeals of the antitrust laws by implication from a regulatory statute are strongly disfavored and have only been found in cases of plain repugnancy between the antitrust and regulatory provisions." *United States* v. *Philadelphia National Bank,* 374 U.S. 321, 348, 350-51. Moreover, even in the rare instances where such "plain repugnancy" has been recognized, any implied immunity is narrowly limited to that "necessary to make [the regulatory scheme] work, and even then only to the minimum extent necessary." *Silver* v. *New York Stock Exchange, Inc.,* 373 U.S. 341, 357. Consequently, this Court has repeatedly emphasized the need to reconcile the regulatory statute at issue with the antitrust laws, and has consistently rejected attempts (such as that by the court below) to carve out "blanket" exemptions to the antitrust laws. *Silver* v. *New York Stock Exchange, Inc.,* 373 U.S. 341, 357. *Accord, Pan American World Airways, Inc.* v. *United States,* 371 U.S. 296, 304-05; *Carnation Co.* v. *Pacific Westbound Conference,* 383 U.S. 213, 217-21; *Hughes Tool Co.* v. *Trans World Airlines,* 409 U.S. 363, 387, 389. *See also Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 390 & n. 7 (Stewart, J., concurring in part and dissenting in part). The decision of the court below runs counter to an unbroken line of decisions by this Court, and fundamentally misconstrues the intent and meaning of the implied immunity doctrine.

A. The decision below extends the doctrine of implied repeal to statutes involving no federal regulatory scheme whatever.

The basic foundation of the implied immunity doctrine is the necessity to resolve conflicts between application of the antitrust laws and the statutory responsibilities of federal

regulatory agencies. As this Court noted in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency entrusted with regulation in the public interest* could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. (Emphasis added.)

The Planning Act creates no federal regulatory scheme at all in the sense that concept is employed in this area, much less a "pervasive" regulatory scheme of the kind this Court has repeatedly required before finding an implied repeal of the antitrust laws. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 347, 360-61; *Hughes Tool Co.* v. *Trans World Airlines*, 409 U.S. 363, 387; *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374; *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352. *See also California* v. *Federal Power Commission*, 369 U.S. 482, 485.

The Planning Act was enacted "to facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning for health service, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b). To accomplish that purpose, the Act established, through a series of grants made by the Department of Health, Education and Welfare [now the Department of Health and Human Services ("HHS")] a nationwide, three-tiered system of health planning and development organizations (*see* 42 U.S.C. §§ 300*l*-1, 300m, 300m-3), and encouraged the states to establish their own "certificate of need" programs to regulate the provision of new or ex-

panded health care services (*see* 42 U.S.C. § 300m).[20] The duties of the Secretary of HHS under this statutory scheme are limited,[21] and include no "regulatory" functions whatever. In short, the Planning Act established a framework for the future development of a national planning policy in which the only "regulatory" function would be served by each state pursuant to its own individualized "certificate of need" legislation.[22] The

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[20] Under the Act, a state is not required to participate in the planning program, but it faces the loss of various grants, loans or contract monies available from the federal government if it fails to do so. 42 U.S.C. § 300m(d).

[21] The primary responsibilities of the Secretary are to issue guidelines concerning national health planning goals (*see* 42 U.S.C. § 300k-1); to establish health service areas (*see* 42 U.S.C. § 300*l*); and to enter into designation agreements for HSAs and State Agencies (*see* 42 U.S.C. §§ 300*l*-4, 300m). The Planning Act also establishes a National Council on Health Planning and Development to advise and make recommendations to the Secretary for the development of national health planning guidelines (*see* 42 U.S.C. § 300k-3), pursuant to which the Secretary has promulgated planning guidelines intended to be used by the HSAs in developing their health plans (*see* 42 C.F.R. §§ 121.201 *et seq.*).

[22] This intention is reflected in the legislative history of the Act:

> Although the keystone to the health planning effort . . . is the areawide health planning agency, certain functions are more appropriately performed at the State level. Specifically . . . the performance of regulatory functions are most appropriately carried out at the State level. . . . [This] function can appropriately be carried out only by an agency of State government. The Committee bill is intended to encourage the establishment of a delicate but workable balance among the varied interests operating in the health care industry today. For that reason, rather detailed and explicit enumerations of the health planning and regulatory functions which can be

(footnote continues)

holding of the court below that this statute created a "blanket" antitrust exemption was based on a fundamental misreading of the implied immunity doctrine which will, if it remains uncorrected by this Court, breed additional uncertainty and confusion among the lower courts as to the basic scope of the implied immunity doctrine[23] and the relationship of that doctrine to the "state action exemption," which this Court only last term sought to clarify in *California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.*, 445 U.S. 97.[24]

(footnote continued)

> carried out at the State level are contained in the legislation. To a very great extent, the manner in which those functions are performed is left to the discretion of the individual Governors of the States involved. [S. Rep. No. 93-1285, 93d Cong., 1st Sess. 52, *reprinted in* 1974 U.S. Code Cong. & Ad. News at 7891.]

[23] *See* "Antitrust and Regulated Industries: A Critique and Proposal for Reform of the Implied Immunity Doctrine," 57 *Tex. L. Rev.* 751, 760, 766 (1979)(noting that doctrine is in a state of confusion, and advocating clarification and reform of the criteria governing application of the doctrine).

[24] Confusion about the impact of the decision below is likely to be especially serious in the Eighth Circuit because of the Eighth Circuit's concurrent disposition of *Sound, Inc.* v. *American Telephone & Telegraph Co.*, No. 80-1047 (8th Cir. Aug. 25, 1980). At issue in *Sound, Inc.* were certain activities of AT&T which AT&T claimed were immune from antitrust scrutiny because the Federal Communications Act as implemented by the FCC had impliedly repealed the application of the antitrust laws to its challenged activities. *Sound, Inc.* and the instant case were the first cases dealing with the doctrine of implied repeal to be heard by the Eighth Circuit. Three days after the petition for rehearing *en banc* in the instant case was denied, *Sound, Inc.* was decided in Sound, Inc.'s favor. Hence, there now exist two Eighth Circuit decisions on implied repeal which are strongly opposed in their application of the principles governing implied repeal of the antitrust laws: the doctrine of implied repeal was held *inapplicable* to a situation involving a significant federal regulatory scheme in *Sound, Inc.*, while it was held *applicable* in the instant case

(footnote continues)

B. The decision below would extend the doctrine of implied repeal to private voluntary conduct subject to no governmental oversight whatever.

Under the principles established by this Court, voluntary private action, even where approved by a public agency with clear regulatory authority, does not necessarily provide antitrust immunity. *See, e.g., United States* v. *Radio Corporation of America,* 358 U.S. 334, 350-52; *California* v. *Federal Power Commission,* 369 U.S. 482, 485; *United States* v. *Philadelphia National Bank,* 374 U.S. 321, 350-52. *See also United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, 744-45 (White, J., dissenting).

In this case, however, we do not have any public agency approval or acquiescence. Rather, we have a totally private scheme subject to no governmental oversight whatever, and "[w]hen these relationships are governed in the first instance by business judgment and not regulatory coercion, courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 374.

In this case, Blue Cross, acting in concert with BCA and others, determined that it would require a favorable "need review" from MAHSA before it would enter into a participating hospital contract. That decision was a voluntary one on the part of Blue Cross and BCA, and was not mandated or authorized by the Planning Act or by any government action, state or federal. MAHSA did not require defendants to do it, nor did MAHSA have the legal authority to approve or sanction the decision by Blue Cross and BCA, even if asked.

(footnote continued)

to a situation involving no federal regulatory scheme at all. This sets the doctrine of implied repeal on its head. Although petitioner requested a rehearing *en banc* in part to encourage the Eighth Circuit prospectively to reconcile its two decisions, the Eighth Circuit declined to do so.

Nor does National Gerimedical have available any relief from the adverse concerted action of Blue Cross, BCA, and others, for no mechanism for administrative or judicial review of voluntary "need" reviews exists under any law. For whatever reasons, Blue Cross and BCA undertook their conduct as if they were governmental agencies with a statutory mandate to limit competition and, in concert with participating Blue Cross hospitals and MAHSA, established a private regulatory system without any right of appeal or direct judicial review.

So far as we can determine, no such purely private action has ever been given antitrust immunity. The reason is clear. Antitrust is extraordinarily unsympathetic to "private government," whatever its motives. *See Fashion Originators' Guild* v. *Federal Trade Commission,* 312 U.S. 457 (involving collective action to bar state law torts), and *American Medical Association* v. *United States,* 130 F.2d 233 (D.C. Cir. 1942), *aff'd,* 317 U.S. 519 (involving new and allegedly "unethical" forms of practice).

This is especially important where immunity by implication is urged. Congress did not expressly grant antitrust immunity for the conduct at issue here, or to any similar conduct. That being so, it is not appropriate to presume a Congressional intention to oust the antitrust laws, with their goal of competitive efficiency, where such a conclusion is not compelled by an inconsistent scheme of public regulation designed to assure due process and mandated goals. For example, in *Gordon* v. *New York Stock Exchange, Inc.,* 422 U.S. 659, and *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, it was the fact of SEC regulatory oversight and authority that was crucial to this Court's conclusion that application of the antitrust laws would be inconsistent with Congressional intent. As Mr. Justice Douglas explained in his concurring opinion in *Gordon* (422 U.S. at 692):

> The antitrust laws are designed to safeguard a strong public interest in free and open competition, and

> immunity from those laws should properly be implied only when some equivalent mechanism is functioning to protect that public interest.

Similarly, in *Hughes Tool Co.* v. *Trans World Airlines, Inc.*, 409 U.S. 363, and *Pan American World Airways, Inc.* v. *United States*, 371 U.S. 296, it was the fact of active CAB oversight over the specific activity in question which was crucial to this Court's conclusion that the antitrust laws were not applicable.

On the other hand, where the private party is the real decision-maker, and where ouster of the antitrust laws will leave the public with neither antitrust nor adequate regulatory protection, neither this Court (nor any other court to our knowledge) has ever found a Congressional intent to exempt such conduct completely from antitrust scrutiny. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. at 353-54, 357;[25] *Otter Tail Power Co.* v. *United States*, 410 U.S. at 374-75; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. at 219; *United States* v. *Philadelphia National Bank*, 374 U.S. at 351. *Cf. California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.*, 445 U.S. at 104-06.

Nevertheless, the court below implied a "blanket" exemption for purely voluntary conduct over which there is no public oversight of any sort. In effect, under the decision below, the application of the antitrust laws to private conduct could be defeated in many cases by a claim by the defendant parties that they undertook their anticompetitive conduct in support of the

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[25] As noted by this Court in *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 683-84:

> In *Silver*, the Court concluded that there was no implied repeal of the antitrust laws in that factual context because the Exchange Act did not provide for SEC jurisdiction or review of particular applications of rules enacted by the exchanges. . . . [*T*]*here was no governmental oversight of the exchange's self-regulatory action, and no method of insuring that some attention at least was given to the public interest in competition.* (Emphasis added.)

public policy goals of enacted federal legislation.[26] This would be a clear distortion of the doctrine of implied repeal.

C. The decision below conflicts with the principles governing implied repeal established by this Court.

In numerous decisions, this Court has established and followed the principle that any implied immunity from the antitrust laws must be narrowly limited to that which is actually required to make the federal regulatory scheme work. *See, e.g., Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 357; *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 719-20; *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 731-36; *United States* v.

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[26] Many other federal statutes have general "cooperation" provisions similar to the provision relied on by the court below, which could conceivably be placed in issue by the decision below. *See, e.g.*, 42 U.S.C. § 4331 (referring to the "continuing policy of the Federal Government, in cooperation with state and local governments and other concerned public and private organizations, to use all practicable means and measures, including financial and technical assistance, in a manner calculated to foster and promote the general welfare, to create and maintain conditions under which man and nature can exist in productive harmony, and fulfill the social, economic, and other requirements of present and future generations of Americans"); 21 U.S.C. § 114d(1) (authorizing the Secretary of Agriculture "to cooperate with other public and private organizations and individuals" in carrying out purposes of the Act); 42 U.S.C. § 3532 (authorizing the Secretary of HUD to "encourage comprehensive planning by the state and local governments with a view to coordinating Federal, State, and local urban and community development activities; [and] encourage private enterprise to serve as large a part of the Nation's total housing and urban development needs as it can and develop the fullest cooperation with private enterprise in achieving the objectives of the Department"); 49 U.S.C. § 1639 (authorizing the Secretary of Transportation to "consult and cooperate, as he deems appropriate, with institutions and private industry").

Borden Co., 308 U.S. 188, 198-200. Consequently, blanket exemptions have been uniformly disapproved by this Court. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 357, and cases cited *supra*, at p. 16.

In this case, the court below found a conflict between the antitrust laws and the general declaration in Section 300*l*-2(c)(1) of the statute (*see* p. 6, *supra*) despite the fact that that section contains no reference to third party payors such as Blue Cross, and despite the fact that MAHSA never sought the assistance of Blue Cross in the enforcement of its "need" standards. If anything, Blue Cross relied on MAHSA and MASHA's planning activity to justify its own unilateral decision to deny participating hospital status. In short, the court below, despite the consistent directives of this Court, did not attempt to reconcile the provision at issue with the antitrust laws, or to read the provision narrowly so as to avoid an unneccessary conflict with the antitrust laws. Instead, it went out of its way to find a conflict in direct contravention of the precedents of this Court, and then, after it had done so, it used that "conflict" to justify a blanket exemption from the antitrust laws—a result which this Court has specifically ruled to be unacceptable (*see, supra*, at p. 16), and which at least one commentator has emphasized "conflicts with [this Court's] restrictive approach to implied repeal." F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980).

The error of the decision below, and its conflict with the decisions of this Court, is made even clearer by the specific limited express immunity from the antitrust and other federal laws contained in the Planning Act.[27] Significantly, that immunity is limited to an "individual" who is either a "member or

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[27] At all times here pertinent 42 U.S.C. § 300*l*-1(b)(4) provided:

> No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized

(footnote continues)

employee" of an HSA, and even then it is limited to conduct "required of, or authorized to be undertaken by, the agency." Obviously, this provision provides no solace to Blue Cross or BCA.

This limited express immunity shows that Congress knew what immunity it wanted to give and did so. This Court has held that it is a basic rule of statutory interpretation—the modern expression of the ancient doctrine of *expressio unius est exclusio alterius*—that the specific statement of a power or exemption is the exclusion of any others. *National Railroad Passenger Corp.* v. *National Association of Railroad Passengers,* 414 U.S. 453, 458. This rule of construction, strong in its own right, is particularly important in antitrust law. Since implied repeals of the antitrust laws are strongly disfavored, this Court has emphasized that where Congress has provided only a narrow and limited immunity, no broader immunity can be inferred. *See Federal Maritime Commission* v. *Seatrain Lines, Inc.,* 421 U.S. at 733; *California* v. *Federal Power Commission,* 369 U.S. at 485; *Carnation Co.* v. *Pacific Westbound Conference,* 383 U.S. at 216-17. Similarly, in *United States* v. *Borden Co., supra,* this Court found that the explicit immunity provisions contained in the Agricultural Marketing Agreement Act defined how far Congress intended that Act should operate to

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(footnote continued)

> to be undertaken by, the agency under this subchapter be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

This provision was amended in 1979, but the amended provision also limits immunity to members of the governing body and employees of an HSA. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, § 110(d)(1), 93 Stat. 603-04 (1979).

render the Sherman Act inapplicable, concluding (308 U.S. at 201):

> If Congress had desired to grant any further immunity, Congress doubtless would have said so.

This reasoning is clearly applicable here, and sharply illustrates the failure of the decision below to conform to the prior decisions of this Court.

CONCLUSION

The decision below presents an issue of public importance which should be decided by this Court, and the decision is in conflict with decisions of this Court.

The petition for certiorari should be granted.

Respectfully submitted,

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ADDENDUM

A. Cases Involving Implied Repeal Now Pending in Lower Courts.

1. *Huron Valley Hospital, Inc.* v. *City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979).

In this case, plaintiff wanted to construct a new hospital and sought approval for such construction, as required by state law. Its application was denied. Six months later, a competing hospital submitted an application for the renovation of its existing facilities. The HSA and the State Agency approved the competing hospital's application. Plaintiff then sued under the antitrust laws, alleging, *inter alia*, that the competing hospital had conspired with the HSA, the State Health Planning and Development Agency, and a health planning group to exclude it from the market. The district court dismissed the action, holding that the state action exemption, the doctrine of implied repeal, and the *Noerr-Pennington* doctrine[28] all insulated the parties' action from antitrust challenge.

2. *North Carolina* v. *P.I.A. Asheville, Inc.*, Civ. No. A-C-80-29 (W.D.N.C., filed Feb. 22, 1980).

In this case the state alleged that defendant had engaged in a conspiracy to eliminate competition in the rendition of private psychiatric hospital services by, *inter alia*, seeking to acquire two additional hospitals in the relevant market area. Under the applicable state legislation, such acquisitions were subject to the approval of the State Health Planning and Development Agency. In its motion for judgment on the pleadings, the defendant contended that its actions were immune from the antitrust laws under the implied immunity, state action and *Noerr-Pennington* doctrines. In addition, defendant contended

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[28] *Eastern R.R. Presidents Conference* v. *Noerr Motor Freight, Inc.*, 365 U.S. 127; *United Mine Workers* v. *Pennington*, 381 U.S. 657.

that the primary jurisdiction doctrine required that the case be stayed until the State Agency had ruled on defendant's application. The district court stayed the action pending the State Agency decision.

B. Statements of Enforcement Intentions by the Department of Justice, Antitrust Division (28 C.F.R. § 50.6).

1. Central Virginia Health Systems Agency Business Review Clearance.

This statement was prompted by a January 25, 1979, letter from the Central Virginia Health Systems Agency, seeking a statement of the Department's enforcement intentions with respect to planning-related activities of the HSA and health care providers in the HSA's service area. The Department, in a letter dated May 6, 1980,[29] concluded that certain of the activities proposed by CVHSA appeared to be contemplated by the Act and said it had no intention of challenging such activities so long as they corresponded to the statutory scheme. However, the Department declined to find that the Planning Act created a complete exemption for all efforts by health systems agencies and private parties working with them to implement their plans. It said:

> [W]e believe that agreements among competing hospitals limiting the number of patients they could serve or the kinds of services they could offer in the absence of conscious and explicit authorization and supervision by the State are probably not contemplated by the Act nor exempt from the application of federal antitrust laws.
>
> * * *
>
> *In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption*

[29] Department of Justice Press Release, May 8, 1980, summarized in *Trade Reg. Rep.* (CCH), May 12, 1980, at 5.

> *for all efforts by HSAs, and private parties working with HSAs, to implement health plans.* An antitrust exemption protecting all activities which arguably furthered the general statutory goals is not, in our view, justified. *The legislative history of the Act reveals no congressional intent to restrict the operation of the antitrust laws to such an extent. Moreover, that interpretation would clearly conflict with the well-established principle that implied repeal of the antitrust laws is disfavored and that antitrust exemptions should be construed narrowly.* [Emphasis added.]

2. Westlake Hospital Business Review Clearance.

This statement, issued by the Justice Department on August 27, 1980,[30] involved a proposed agreement between the Westlake Hospital Campus Association, Westlake, Ohio, and Lakewood Hospital, Lakewood, Ohio, in settlement of lawsuits between the two institutions, which provided that the Association would not offer specified health care services at its hospital for a certain period of time. The Department declined to grant the requested clearance. It said:

> Agreements between competitors as to the products or services that each will offer are prohibited by the antitrust laws because of their plainly anticompetitive purpose and effect. State and federal regulatory programs reflect a legislative judgment that if competition is to be restrained, it should be restrained by the appropriate regulatory agencies, and not by private agreements. The agreement has not been authorized or required by any regulatory agency and is not subject to governmental supervision. It has not been addressed by the health systems agency plan

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[30] Department of Justice Press Release, August 29, 1980, summarized in *Antitrust & Trade Reg. Rep.* (BNA), September 11, 1980, at A-12.

> and has not been authorized or required by the health systems agency or the state health planning and development agency. Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need Application from an otherwise qualified applicant. *These considerations also preclude application of any implied antitrust exemption that may arise from the National Health Planning and Resources Development Act, 42 U.S.C. § 300k et seq., from which the state regulatory scheme is derived.* Accordingly, the Department cannot state an intention not to sue to enjoin the proposed agreement. [Emphasis added.]

C. Statement of Enforcement Intentions by the Attorney General of Virginia

In a business review letter issued January 29, 1979,[31] the Attorney General of Virginia declined to clear a plan whereby hospitals would enter into agreements allocating beds for obstetrical services among themselves pursuant to a request by the HSA that they do so. The attorney general concluded that the proposed conduct was not exempt from the state antitrust laws:

> The conduct you propose is not part of the State Health Plan, it has not been approved by any State or federal agency, it is neither required nor compelled by either the Act or its State counterpart, or any agency of either. Consequently, the conduct is not expressly exempt from the reach of the Virginia Antitrust Act. Moreover, since the conduct is not necessary to the regulatory framework established by the Act, it is not impliedly exempt from the reach of the antitrust laws.

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[31] This letter is summarized in *Antitrust & Trade Reg. Rep.* (BNA), March 1, 1979, at D-5 and D-6.

APPENDIX A

OPINION OF THE COURT OF APPEALS

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLIAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others[1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court[2] found Blue Cross' activities to be taken pursuant to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.;* that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from the antitrust laws. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross,* 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

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* The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

[1] Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several nondefendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

[2] The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia,* the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc.* v. *Indiana State Board of Health,* 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies. *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had

not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia,* "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It

is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendent alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW on April 7, 1976. *Mid-America Regional Council* v. *Mathews,* 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

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[3]*See* note 1 *supra.*

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra.* 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.,* a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra,* was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra,* Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973, refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of

Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.

In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

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[4] Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the

intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc.* v. *AT&T,* 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown,* 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon* v. *N.Y. Stock Exchange,* 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S.* v. *Southern Motor Carriers Rate Conference,* 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business

> entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.
>
> The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business entities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. *AT&T, supra,* 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

> Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the

federal aqency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws." *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's

> immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Althouqh recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might

be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation .... In doing so, the HSA may develop institution-specific recommendations; ... or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

... congressional intent was for the HSA, the congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and

> providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

APPENDIX B

OPINION OF THE DISTRICT COURT

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IN THE
United States District Court
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

No. 78-0359-CV-W-3

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY, *et al.*,
Defendants.

Order

(filed November 2, 1979)

On May 23, 1978, plantiff, National Gerimedical Hospital and Gerontology Center (hereinafter referred to as National Gerimedical) filed a complaint against Blue Cross of Kansas City and Blue Cross Association alleging violations of the antitrust provisions of state and federal statutes.

Count I of the complaint alleges that the defendants and various named co-conspirators have engaged in a conspiracy in restraint of trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff alleges in Count II that the defendants engaged in a continuing combination and conspiracy to boycott National Gerimedical in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count III alleges that defendant Blue Cross Association and Blue Cross of Kansas City and their co-conspirators have combined and conspired in a continuous combination and conspiracy to boycott plaintiff hospital and coerce all Blue Cross subscribers to refuse to deal with plaintiff,

in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count IV alleges that the defendants' actions were an effort to control market entry and dictate terms of access to the health care services market and constitute an unlawful abuse of monopoly power in violation of § 2 of the Sherman Act, 15 U.S.C. § 2. Counts V through VIII allege violations of similar provisions of the state antitrust laws, Missouri Revised Statutes § 416.031-1 through § 416.031-2.

On July 14, 1978, defendant Blue Cross Association and defendant Blue Cross of Kansas City filed motions to dismiss plaintiff's amended complaint. After considering the parties' suggestions in support and in opposition thereto, the Court refrained from deciding the issues raised by the motion to dismiss pending the Supreme Court's decision in *Group Life and Health Ins. Co.* v. *Royal Drug Co.* Subsequent to the Supreme Court decision in that case on February 27, 1979, the parties have briefed the issue of the application of that case to the present facts. The defendants base their motion to dismiss the federal causes of action on essentially four grounds: (1) The conduct complained of is exempted from the antitrust laws by the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015; (2) the National Health Planning & Resource Act of 1974 impliedly repealed the antitrust laws where the challenged conduct is necessary to effectuate the purpose of the Act; (3) plaintiff's complaint does not allege any ultimate facts to support a claim that the defendants engaged in a conspiracy within the meaning of the antitrust laws; and (4) prepaid medical plans offered by not-for-profit corporations are not "trade or commerce" within the meaning of the Sherman Act. Additionally, the defendants argue that if the federal claims are dismissed for lack of jurisdiction, the Court should exercise its discretion and dismiss the pendent state claims.

In an order issued October 11, 1979, this Court indicated that because it was considering matters outside the pleadings presented by the parties, it would treat the motion to dismiss as one for summary judgment in accordance with Rule 12(b)(6)

of the Federal Rules of Civil Procedure. The parties were given an opportunity to present additional evidence or to oppose this action. All parties have indicated that they have no further evidence to present and do not oppose this treatment by the Court.

Rule 56(c) provides in part that summary judgment should be granted when:

> ... the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

It is well established that in considering a motion for summary judgment, the Court examines the evidence not to decide issues of fact but to determine if any real issues exist. *Krupin* v. *United States,* 439 F. Supp. 440 (E.D. Mo. 1977); *Bazzano* v. *Rockwell International Corp.,* 439 F. Supp. 1167 (E.D. Mo. 1977). The existence of some disputed facts in a case does not necessarily preclude the Court from granting summary judgment. To preclude summary judgment, the disputed facts must be material and of the type that would affect the outcome of the litigation. *Hahn* v. *Sargent,* 523 F.2d 461, 464 (1st Cir. 1975). Where legal questions of statutory construction involving legislative history and policy are concerned, summary judgment is an appropriate mechanism for disposing of these issues. *Mobil Oil Corp.* v. *Federal Energy Adm.,* 566 F.2d 87, 91-2 (T.E. App. 1977).

The Eighth Circuit has consistently recognized that summary judgment is an extreme remedy which should not be granted unless the movant establishes his right to judgment with such clarity as to leave no room for controversy. *Ledwith* v. *Douglas,* 77-1463, (January, 1978); *Unlaub Co.* v. *Sexton, Inc.,* 77-1293 (8th Cir. 1977).

In considering this motion the Court must view the facts most favorably to the party opposing the motion and give that

party the benefit of any reasonable inferences to be drawn from the facts. *Ledwith, supra; Unlaub, supra; New England Mutual Life Ins. Co.* v. *Null,* 554 F.2d 896, 906 (8th Cir. 1977). From all of the pleadings the Court has reviewed, it would appear that there is no material dispute as to the following facts which are a summary of the essential allegations of plaintiff's complaint by Blue Cross of Kansas City:

1. Plaintiff is a Missouri not-for-profit corporation which will open a *new* hospital on or about July 30, 1978 (Paragraph 3, Complaint);

2. Defendant Blue Cross of Kansas City is a Missouri not-for-profit Health Service corporation which offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas, and which contract with member hospitals and with other health service provides for the administration of its health care reimbursement plans (Paragraph 4, Complaint);

3. Blue Cross is a major provider of private health care plans in Western Missouri and Eastern Kansas (Paragraph 13, Complaint);

4. All acute general care hospitals except plaintiff in the Blue Cross service area have contracted with Blue Cross and thus are "participating" hospitals. (*Ibid.*);

5. Blue Cross reimburses its individual subscribers for 100% of all covered hospitals services, by direct payment to the hospital, for services at a participating hospital (*Ibid.*);

6. Blue Cross subscribers receive payment for 80% of covered hospital services performed at a non-participating hospital, which reimbursement is paid directly to the subscriber, not the hospital (*Ibid.*);

7. Blue Cross denied plaintiff a participating Member Contract solely because plaintiff failed to demonstrate a need for its hospital (Paragraph 17, Complaint);

8. Among the "Prerequisites" for membership in Blue Cross, was the requirement that a hospital "meet a clearly evident need for health care services in its defined service area." (Paragraph 18, Complaint);

9. In order to determine "clearly evident need" Blue Cross designated Mid-America Health Systems, Inc. ("MAHSA") a not-for-profit, non-governmental organization, engaged in the voluntary evaluation of health care services in Missouri and Kansas as the agency to conduct "need review" (Paragraphs 6 and 18(a), Complaint);

10. Blue Cross will not contract with any hospital as a "participating member hospital without MAHSA approval of need" (Paragraph 18(a), Complaint);

11. MAHSA has no power to impose sanction to enforce its determinations nor to compel review (Paragraph 18(b), Complaint);

12. MAHSA has publicly stated that it will disapprove and not consider favorably the addition of any acute care hospital beds.

Plaintiff's answers to interrogatories clarify one point. National Gerimedical Hospital's initial application to become a Blue Cross member hospital was made October 4, 1977 and was amended and resubmitted on February 15, 1978. (*See* Plaintiff's answer to Interrogatory No. 9, Ex. D.) On March 21, 1978 National Gerimedical Hospital was denied member status because it had not received approval through the voluntary health planning process. National Gerimedical has indicated that it never sought review by Mid-America Health Systems Agencies. (*See* Plaintiff's answer to defendant's interrogatory No. 16, Ex. F.) Thus this is not a situation where Mid-America Health Systems has refused to issue a certificate of need to National Gerimedical Hospital, but rather plaintiff is challenging the policy of Blue Cross requiring them to seek Mid-America Health Systems' approval.

Application of McCarran-Ferguson Act

§ 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) and (b) provides in part:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

In essence this Act has been interpreted to exempt the application of the antitrust laws from the business of insurance if it is regulated by the state and if the challenged action does not involve a boycott, coercion or intimidation. In determining the initial applicability of the McCarran-Ferguson Act, two questions must be answered: (1) are the defendants engaged in "the business of insurance" and (2) is the challenged conduct regulated by state law? In order for the activity to be exempt from the application of the antitrust laws, both of the above criteria must be satisfied.

The briefs of Blue Cross of Kansas City and Blue Cross Association submitted in July of 1978 cited numerous case decisions holding that hospital-provider contracts are the business of insurance, regulated by state law, and thus exempt from application of the antitrust laws. Had the Court been deciding this issue prior to February 27, 1979, it would have adopted the rationale of these decisions and found that hospital payments

and subscriber rates were so interrelated that Blue Cross contracts with hospitals were a part of the business of insurance. Additionally, the Court would have found that the requirements of state regulation of the business of insurance had been met. However, the Court believes that in light of the language used by the Supreme Court in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 59 L.Ed.2d 261 (1979) the rationale of these earlier circuit court opinions is no longer valid.

In Royal Drug eighteen owners of independent pharmacies sued Blue Shield of Texas. Blue Shield offers insurance policies on prescription drugs. If an individual covered by one of these policies utilizes a pharmacy which has entered into a "pharmacy agreement" with Blue Shield, the insured pays $2.00 and the remainder of the prescription price is paid by Blue Shield. If the pharmacy selected is a non-participating pharmacy and has not signed such an agreement with Blue Shield, the individual must pay the full price charged for the drug by the pharmacy. The insured can then obtain a reimbursement for 75% of the difference between the price charged minus $2.00. Under the agreement Blue Shield agreed to reimburse a participating pharmacy for the pharmacy's cost of acquiring the drug plus the $2.00 paid by the individual. Thus only pharmacies that could afford to distribute prescription drugs for less than the $2.00 markup could profitably participate in the plan. In determining if the contract between Blue Shield and the pharmacies was exempt from the application of the antitrust laws because of the McCarran-Ferguson Act, the Court identified one of the primary elements of an insurance contract as the spreading and underwriting of the policyholder's risk. Petitioners in the *Royal Drug* case argued that these pharmacy agreements did involve the underwriting of risk. Although the Court recognized that some type of provider agreement will be necessary for the existence of a service benefit plan, the Supreme Court was unwilling to infer that because an agreement is necessary to provide insurance, it is also "the business

of insurance." *Royal Drug, supra* at 270 ftn. 9. In rejecting this argument, the Court found:

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.
>
> * * *The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."
>
> The Pharmacy Agreements are thus legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keep low the level of premiums charged to their policyholders. *Royal Drug, supra* at 269-270.

Another reason for rejecting the claim that these contracts involved the business of insurance was the fact that the contracts in the the *Royal Drug* case were not between insurer and insured but were separate contractual arrangements between Blue Shield and the pharmacies engaged in the sale and

distribution of goods and services other than insurance. The Court stated:

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. The manager of an insurance company is no different from the manager of any enterprise with the responsibility to minimize costs and maximize profits. If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance". Such a result would be plainly contrary to the statutory language, which exempts the "business of insurance" and not the "business of insurance companies." *Royal Drug, supra* at 271-272.

Defendants have attempted to distinguish the *Royal Drug* case on the grounds that the provider contract involved here contain the indispensable characteristic of insurance, *i.e.* the underwriting and spreading of risk. In support of this argument, the defendants suggest:

> Under the provider contract Blue Cross agrees to reimburse hospitals for services rendered to its subscribers *only so far as current earned income will permit.* (Article IVA, Provider Contract). Unless provisions for all expenses and allocations to reserves have been each month, earned income cannot be used to pay hospitals (Article IVC, IVD). If Blue Cross does not have sufficient funds to pay benefit payments in full to hospitals, each of the provider

> hospitals is to receive only a portion of the benefit payments on a pro rata basis from Blue Cross. [pp. 3-4, Reply of Blue Cross of Kansas City To Supplemental Suggestions of National Gerimedical Hospital in Opposition to Defendants' Separate Motions to Dismiss filed April 9, 1979.]

Were the Court to agree with defendants' interpretation of the contract, it is doubtful if *Royal Drug* would be sufficiently distinguished to render its holding inapplicable. However, the Court's interpretation of the provider contract in this case is not totally in accord with the defendants. Article IVB does require reserves to be maintained by Blue Cross sufficient to provide for three months operating expenses and benefits for hospital services. After provisions for reserves have been made, benefit payments each month are to be made to the hospitals equal to the amount of benefits due for all claims processed by Blue Cross. If sufficient funds are not available, adjustment on a pro rata basis is to be made; however, Article 4D provides:

> D. If benefit payments to HOSPITAL for Hospital Service are reduced because of the application of Article IV, C above, BLUE CROSS agrees to pay pro rata the amount of such reduction to all hospitals as current earned income becomes available for such purpose.

Thus, the risk of nonpayment does not fall on the hospital as the defendants suggest, but payment is eventually to be made as funds become available on a pro rata basis.

Comparison of the Blue Cross provider contracts in this case and the Blue Shield pharmacy agreements in *Royal* have convinced the Court that no rational basis for distinguishing these contracts exist. Further, the language of the Supreme Court seems to clearly imply that such distinctions should not be drawn and would be looked on with disfavor.

> If agreements between an insurer and retail pharmacists are the "business of insurance," because

> they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies". But that is precisely what Congress did not do. *Royal Drug, supra* at 281.

The Supreme Court went on to add:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders—such as agreements with hospitals, doctors, lawyers and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws. *Royal Drug, supra* at 281.

Therefore, defendants' motions for summary judgment on the basis that the conduct in this case involved "the business of insurance" and is thus exempt from the antitrust laws under the McCarran-Ferguson Act must be denied.

Implied Repeal of The Antitrust Laws

Secondly, the defendants have moved to dismiss the federal causes of action on the grounds that the National Health Planning and Resource Development Act of 1974 impliedly repealed application of the federal antitrust laws in the instant case. The doctrine of implied immunity or implied repeal of the antitrust laws is a judicially created exemption

from the application of the antitrust laws which has been utilized to resolve potential conflicts between federal or state regulatory schemes and the antitrust laws. The Supreme Court has indicated that implied immunity has been adopted and applied:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency* entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.

A number of well established principles can be derived from cases that have considered this doctrine. First, any immunity from the antitrust laws should not be lightly implied and repeal by implication is not favored. *Gordon* v. *New York Stock Exchange,* 422 U.S. 659, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975); *U.S.* v. *American Telephone & Telegraph Co.,* 427 F. Supp. 57 (E.D. La. 1976). In considering a claim of implied repeal of the antitrust laws, the Court should first attempt to reconcile the operation of the antitrust laws and the regulatory statutes. *Essential Communication* v. *American Telephone & Telegraph,* 446 F. Supp. 1090 (D.N.J. 1978). If reconciliation is not possible, for the reason that a clear repugnancy exists between the statutes or the particular provisions at issue and the antitrust laws, then an exemption may be created; however, the antitrust laws should be repealed only to the extent necessary to make the regulatory statute effective and then only to the minimum extent needed. *Gordon, supra* at 479. *Mount Hood Stages* v. *Greyhound,* 555 F.2d 687 (9th Cir. 1977); *Oahu Gas Service, Inc.* v. *Pacific Resources, Inc.,* 460 F. Supp. 1359 (D. Ha. 1978); *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 385 (S.D.N.Y. 1976); see Application of Federal Antitrust Laws as Affected by Other Federal Statutes or the Federal Constitution, Annotation 45 L.Ed.2d 841.

After determining a conflict exists, the Court must also consider the manner in which Congress envisioned the conflict to be resolved. Therefore, the Court is faced with two issues in determining the effect of the National Health Planning and Resource Development Act of 1974. First, is there a conflict between this legislation and the antitrust laws. Secondly, how should that conflict be resolved.

In resolving the first issue, the Court must examine the 1974 National Health Planning and Resource Development Act. This Act was essentially composed of four parts: First, National Health Planning and Development, 42 U.S.C. § 300k through 300n-5; second, assistance for construction and modernization of health facilities; third miscellaneous provisions on the transition to the new program; and fourth, the Radiation, Health & Safety Act of 1974 amending the Public Health Service Act in this area. *See* Volume 4, U.S. Code Cong. & Adm. News (1977) p. 7842. The only portion of the Act with which the Court is concerned in this case is Subchapter XIII entitled "National Health Planning and Development".

The National Health Planning and Development portion of the Act established national health priorities. The Secretary of HEW was directed to issue guidelines concerning national health planning goals after considering the national health priorities established by Congress in this section of the Act. Two goals that were established by the Act and of special concern to Congress as evidenced in the Act and in its accompanying legislative history were: (1) reduction of hospital costs; and (2) elimination of unnecessary duplication of health care facilities. The Secretary was also directed to set standards concerning the appropriate supply, distribution and organization of the nation's health resources. *See* 42 U.S.C. §300k-1 through 300k-2. The National Advisory Council on health planning and development was established to advise and consult with HEW and to make recommendations to that department concerning the development of appropriate guidelines. 42 U.S.C. §300k-3.

The Act provided for the establishment of health service areas in accordance with a number of very specific requirements set forth in 42 U.S.C. § 300*l*. To service these areas, health systems agencies were to be established in each health system area. These agencies were given responsibility for health planning and resource development in their particular area. 42 U.S.C. § 300*l*-2(b). Each health systems agency was to adopt a health service plan and an annual implementation plan. The functions assigned to the health service area were to effectuate the purposes of: (1) improving the health of the residents of their area; (2) increasing accessibility, acceptability and quality of the health services provided in their area; (3) restraining increases in the cost of health care; and (4) preventing unnecessary duplication of health resources. 42 U.S.C. §300*l*-2. Procedures were also established for a state health planning and development program. The Act further provided that to implement the health service plan and the annual implementation plan, the Health Service Agency should seek the assistance of individuals, public and private entities, in its health service area. *See* 42 U.S.C. § 300*l*-2(c)(1). It thus appears that the Act authorized and anticipated that the health service agency established by its provisions would consult and work with private health care providers to attempt to achieve voluntary cooperation with the goals of the agency and of the Act.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act and conditionally designated as the health planning body for the eight county bi-state area encompassing the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and Johnson, Levenworth and Wyandotte in Kansas. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The

health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at p. 6-19.)

The goal in this area was recognized as:

> **Goal:** Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at p. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at p. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at p. 6-22.)

The certificate of need requirement voluntarily adopted by Blue Cross of Kansas City seems to be authorized by the Act as well as the implementation plan of MAHSA.

In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions—specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes nonapplication of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges. The proper issue in this case then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the antitrust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.

The National Health Planning and Resource Development Act clearly attempted to set forth health care goals and a regional administrative framework within which achievement of these goals could be sought through cooperation and voluntary compliance with the health care industry. If the Court were to find that private business working in conjunction with the health system agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust law for their action, then the Court believes that the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

Having determined that a conflict exists, the Court must consider the method for resolving the discrepancy. The entire concept of the Act as well as the legislative history convinces the Court that the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act. In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. *See Essential Communities* v. *American Telephone & Telegraph,* 446 F. Supp. 1090 (D.N.J. 1978). The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." *See* Volume 4, U.S. Code Cong. & Adm. News at p. 7878. In the Committee's view:

> The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance progams, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Adm. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Adm. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers

> attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Adm. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Adm. News, at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Adm. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers

expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.
>
> Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation. . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be

> consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.
>
> . . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.
>
> Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962–H11963.

A review of the Act and its legislative history compels this Court to concur with Representative Rogers' analysis of congressional intent in enacting the National Health Planning and Resource Development Act. It should be noted that congressional failure to include specific antitrust exemptions for the activities challenged in this case may in part be accounted for by the status of the case law in 1974. The majority of courts confronted with the issue at that time had held that third party reimbursement contracts came within already existing statutory exemptions under the McCarran-Ferguson Act. The fact that this ex-

emption no longer applies in the instant case does not detract from the clear Congressional intent that activities in the health care area to reduce cost and eliminate duplication would not be subject to challenge under the antitrust statutes.

The defendants in support of their claim of implied repeal cite the March 2, 1979 decision of the United States District Court for the Eastern District of Michigan in *Port Huron Valley Hospital, Inc.* v. *City of Pontiac, et al.,* (attached as Exhibit C to the brief of Blue Cross of Kansas City filed April 9, 1979). A review of Judge Kennedy's opinion in *Port Huron* reveals that the existence of circumstances not present in this case were crucial to the reasoning and outcome there. In *Port Huron* the State of Michigan had adopted certificate of need legislation. Although such legislation is contemplated by the provisions of the National Health Care Planning and Research Development Act, *see* 42 U.S.C. 300m1-5, Judge Kennedy's decision relied on the potential conflict between the state regulation and the federal antitrust laws. The Court does not view *Port Huron* as precedent for its decision in this case. However, it recongizes that the creation of an exemption from the antitrust laws where state certificate of need legislation is passed to insure compliance with the federal act and application of the antitrust laws in instances of voluntary compliance with the federal act would be anomalous. Although not essential to the decision, the Court in *Port Huron* did find that the legislative history of the National Health Care Planning & Resource Development Act demonstrated congressional intent to at least partially repeal the antitrust laws. In fact Judge Kennedy found that it was the purpose of the Act to check the competition of the free market in the health services area. The Court would concur in this assessment of the Act.

On the basis of the factors outlined above, the Court finds: (1) a clear repugnancy exists between the National Health Care Planning & Resource Development Act and the antitrust laws; (2) Congress intended that action taken pursuant to the Act and clearly within the scope of the Act would be exempt from application of the antitrust laws. Therefore, the defendants' motion for summary judgment Counts I through IV on the

grounds that the challenged conduct is exempt from the antitrust laws will be granted.

Two other issues were raised by the defendants which the Court will briefly discuss.

FAILURE TO STATE A CONSPIRACY CLAIM

Defendants characterize the statements concerning the conspiracy as conclusionary and maintain that these allegations are not supported by any allegations of material fact. To maintain a cause of action under § 1 of the Sherman Act a party must set forth the following allegations:

> (1) That the defendants contracted, combined, or conspired among each other; (2) that the combination or conspiracy produced adverse, anti-competitive effects within relevant product and geographic markets; (3) that the objects of and the conduct pursuant to that contract or conspiracy were illegal; and (4) that the plaintiff was injured as a proximate result of that conspiracy. *Martin B. Glauser Dodge Co.* v. *Chrysler Corp.*, 570 F.2d 72, 81 (3rd Cir. 1977).

The Eighth Circuit has emphasized that the complaint need not set forth specific facts to support its general allegations. *Great Atl. & Pac. Tea Co.* v. *Amalgamated Meat Cutters & Butchers Workmen of North American Local No. 88,* 410 F.2d 650, 652 (8th Cir. 1969). The Court finds that judged by these standards the conspiracy allegations are sufficiently detailed to meet the above requirements and the complaint is not subject to dismissal for failure to allege ultimate facts supporting this theory.

The defendants also argued that sufficient facts are not alleged to demonstrate a boycott within the meaning of § 2(b) of the McCarran-Ferguson Act. Even if the business of

insurance regulated by the state is involved so that generally the antitrust laws are inapplicable to a particular activity, an exception to this general rule is created by § 2(b) of the McCarran-Ferguson Act for concerted activity constituting a boycott, coercion or intimidation. Defendants had argued that even if the Court found that the business of insurance regulated by the state was involved, this exception mandated application of the antitrust laws. The issue of whether plaintiff has alleged sufficient facts to demonstrate that the boycott provisions of § 2(b) apply need not be reached since the Court finds that the exemption of the McCarran-Ferguson Act for the business of insurance does not apply.

INTERSTATE COMMERCE REQUIREMENT

Finally the defendants have moved to dismiss the complaint on the grounds that prepaid medical plans offered by not-for-profit corporations are not trade or commerce within the meaning of the Sherman Act. Section 1 of the Sherman Act provides in part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . .

Restraint of trade or commerce is within the prohibition of the commerce requirement only if that restraint affects trade or commerce among the several states or with foreign nations. This effect on commerce requirement is therefore jurisdictional in nature and may be demonstrated in one of two ways. One formulation of the commerce requirement is the "flow of commerce" or qualitative test wherein the restraint complained of is placed directly on goods or services which are themselves in the flow of interstate commerce. Secondly, the requisite commerce requirement may be demonstrated by a quantitative test which involves transactions that although wholly intrastate

substantially affect the flow of interstate commerce. *See* Von Kalinowski, 1 Antitrust Laws and Trade Regulations § 501[1]-[3].

Plaintiffs allegations appear to fall under the latter theory. Paragraph 15 of plaintiff's complaint states that National Gerimedical is one of the first hospitals in the United States specializing in health care services for the elderly. As such, it is intended to serve a national constituency through research and the development of improved health care for the aged. Involvement and effect on interstate commerce is alleged to exist because National Gerimedical is intended to service out of state patients, purchase drugs and supplies from out of state sources, receive income and make disbursements from out of state insurance, and receive out of state financing for construction and operation. Plaintiff's complaint further indicates that Blue Cross's denial of participating status will foreclose to plaintiff a significant portion of the health care market thus affecting the services rendered to out of state patients, the ability to purchase from out of state sources, and the utilization of out of state financing and insurance proceeds. While these allegations are not as specific as might be desired, the Court finds that this issue is controlled by the decision in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). In Trustees of Rex Hospital plaintiff contended that defendant, a competing hospital, had conspired to restrain plaintiff's planned expansion of facilities in violation of § 1 and § 2 of the Sherman Act. Although the only contended effects on interstate commerce stemmed from plaintiff's provision of intrastate hospital services, the Court concluded that a substantial effect on interstate commerce had been alleged. The Court ruled:

> The complaint, fairly read, alleges that if respondents and their coconspirators were to succeed in blocking petitioner's planned expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies

> would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-state parent corporation would be less if the expansion were blocked. Moreover, the multimillion-dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act. *Trustees of Rex Hospital, supra* at 343-4.

In reaching this decision the Court rejected an argument that the conduct is outside the scope of the Sherman Act because the effect on commerce is indirect and the conduct producing the effect not purposefully directed toward interstate commerce. Additionally, the Court found that an effect on commerce may be substantial under the Sherman Act even if its impact on interstate commerce falls far short of causing enterprises to fold or affecting market prices. In the final analysis, allegations that:

> . . . fairly claim that the alleged conspiracy, to the extent it is successful, will place "unreasonable burdens on the free and uninterrupted flow" of interstate commerce, they are wholly adequate to state a claim. *Trustees of Rex Hospital, supra* at 345.

Defendants argue that prepaid medical plans are not trade or commerce and rely on *United States* v. *Oregon State Medical Society,* 343 U.S. 326, 72 S.Ct. 690, 96 L.Ed.2d 978 (1951). In the Court's view, *Oregon State Medical Society* is not controlling the instant case. In *Oregon State Medical Society* it was alleged that the state medical association and local medical organizations had agreed not to compete in particular areas in offering their prepaid medical plans. The Court found that the sale of medical services through these prepaid plans was not trade or

commerce. The challenged conduct here involves contracts or potential contracts between Blue Cross and the supplier of actual hospital services. Plaintiff's claim that the action complained of will affect the ability of National Gerimedical to provide the desired hospital services is indistinguishable from the effect that plaintiff's action was alleged to have caused in *Trustees of Rex Hospital.*

For the above reasons, the Court believes the allegations of the complaint establish that failure to obtain status as a "participating hospital" will have an effect on interstate commerce. Therefore, the defendants' motions for summary judgment on the grounds that the requisite effect on trade or commerce has not been alleged will be denied.

PENDENT STATE CLAIMS

Having determined that dismissal of Counts I through IV is appropriate, the Court must decide whether to retain the pendent state claims encompassed in Counts V through VIII. The Court recognizes that it has the power to decide the state claims. The issue is one of discretion. In *United Mine Workers* v. *Gibbs,* 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966), the Surpreme Court wrote:

> It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims, even though bound to apply state law to them. . . . Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surer-footed reading of applicable law. Certainly, if the federal claims are dismissed before trial, even though

not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.

Gibbs seemed to mandate dismissal of state claims where the federal claims were dismissed prior to trial. However, this aspect of *Gibbs* has been relaxed by subsequent Supreme Court cases. *See Rosado* v. *Wyman,* 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442, 450-1 (1970).

Considerations of judicial economy, convenience and fairness to the litigants should be the determinative factors in deciding whether the Court should exercise its pendent jurisdiction or dismiss the State claims. *See Gibbs, supra; Rosado, supra; Blake* v. *Town of Delaware City,* 441 F. Supp. 1189, 1204-5 (D. Del. 1977). If hearings have been held in a case pending before the Court, discovery conducted and substantial work done towards preparing the action for trial, judicial economy might dictate retaining jurisdiction over the state claims. In this case however, no extensive discovery has been conducted on any issue other than the motion to dismiss and pending a ruling on the motion to dismiss, no answer has even been filed. Further, the issues researched and briefed by the parties involve federal claims and no issues under the state claims have yet been addressed by the parties or the court; thus, judicial economy does not mandate the retention of the state law claims in this instance. Further, this is not a case where dismissal of the parties will leave the plaintiff without an adequate state forum. Therefore, fairness does not mandate retention in this case. Additionally, the factual situation set forth in plaintiff's complaint may involve unique applications of the state antitrust laws. The Court believes that state courts should be allowed to consider issues involving state antitrust laws which will undoubtedly be raised for the first time by this case. It is a well established principle that needless decisions of state law should be avoided as a matter of comity and to procure for the parties "a surefooted reading of applicable law." *See Gibbs, supra;* and *Euster* v. *Pennsylvania State Horseracing Commission,* 431 F. Supp. 828 (E.D. Pa. 1977).

For the above reasons, the Court believes that a proper exercise of its discretion necessitates dismissal of the pendent state claims.

For all of the reasons outlined above, it is hereby

ORDERED that defendants' motion to dismiss which has been treated as a motion for summary judgment is hereby granted and summary judgment is entered in favor of defendants and against plaintiff on Counts I through IV of plaintiff's complaint; and it is futher

ORDERED that in the exercise of its discretion, the pendent state claims set forth in Counts V through VIII are also dismissed without prejudice.

.....

RUSSELL G. CLARK, Judge
United States District Court

Dated: November 2, 1979

APPENDIX C

JUDGMENT OF THE COURT OF APPEALS

JUDGMENT

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

APPEAL FROM the United States District Court for the Western District of Missouri.

THIS CAUSE came on to be heard on the original designated record of the United States District Court for the Western District of Missouri and briefs of the respective parties and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court, in this cause, be, and the same is hereby, affirmed in accordance with the opinion of this Court.

July 22, 1980

Costs taxed in favor of Appellee, Blue Cross Assn:	
Costs of printing 10 copies of brief:	$726.34
Total costs of Appellee, Blue Cross Assn., for recovery from Appellant in the U.S. District Court:.....	$726.34

A true copy

ATTEST: ROBERT D. ST. VRAIN
Clerk, U.S. Court of Appeals, 8th Circuit

APPENDIX D

ORDER DENYING PETITION FOR REHEARING

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United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Appellant,

vs.

BLUE CROSS OF KANSAS CITY, et al.,
Appellee.

ORDER

The Court, having considered appellant's petition for rehearing and suggestions for rehearing *en banc* and being now fully advised in the premises, hereby orders the petition for rehearing and suggestions for rehearing *en banc* denied.

August 22, 1980